PREFERENCE BENEFICIARY AFFIDAVIT

IMPORTANT: PLEASE REFER TO THE REVERSE SIDE OF THIS FORM

THE HARTFORD

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
HARTFORD LIFE INSURANCE COMPANY
HARTFORD FIRE INSURANCE COMPANY
(known collectively as The Hartford)

Name of Deceased	Claim Number	Policy Number
Martha A Stoerz	W-444457	6142112

NOTE: This affidavit is to be used *whenever no beneficiary was designated, or no designated beneficiary survived the deceased.* It is to be completed only by the person or persons within the first surviving class of the following classes of successive preference beneficiaries of the deceased: 1) widow or widower; 2) children; 3) parents; 4) executors or administrators. FOR THE PURPOSE OF inducing The Hartford to recognize the person(s) named herein as the preference beneficiary(ies) entitled to payment, the undersigned does answer as follows and agrees to reimburse The Hartford for any improper payment which is made based upon the information contained in this affidavit.

State or Province of _____ County of _____

3/17/09 4:46:43
M BK 2 PG 245
DESOTO COUNTY, MS
W.E. DAVIS, CH CLERK

I, _____ residing at _____ being first duly sworn, depose and state:

WIDOW OR WIDOWER That I am the surviving spouse of the deceased person named above.

My birth date is _____ (Signed) _____

Social Security # _____ (Phone) ( ) _____

SON OR DAUGHTER That the deceased person above left no surviving spouse; that I am a child of the deceased; and that the deceased left no surviving children other than myself and those listed below: (Use separate sheet, if necessary.)

NAME	*ADDRESS*	*DATE OF BIRTH*	*SOCIAL SECURITY NO.*
Richard A Stoerz	4090 Redwood Olive Branch MS 38654	5-24-58	[redacted]

SIGNED Richard A Stoerz PHONE (662) 895-1454

FATHER OR MOTHER That the deceased named above left no surviving spouse or child(ren); that I am a parent of the deceased; and that the other parent is listed below:

NAME	*ADDRESS*	*DATE OF BIRTH*	*SOCIAL SECURITY NO.*

SIGNED _____ PHONE ( ) _____

EXECUTOR OR ADMINISTRATOR That the deceased person named above left no surviving spouse, child, parent, and that I am the executor or administrator of the estate of the deceased.

SIGNED _____ PHONE ( ) _____

ADDRESS _____ TAX ID NUMBER _____

NOTARIZATION:

Subscribed and sworn to before me this 17th day of March, 2009

Susan D. McMillian
Notary Public

Susan D. McMillian
Affiant's full name

SUSAN D. MCMILLIAN NOTARY PUBLIC DESOTO COUNTY, MS My Commission Expires April 1, 2011

Seal

LC-7086-2 Printed in U.S.A.

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Mail to: The Hartford
Group Life/AD&D Claims Unit
P. O. Box 2999
Hartford, CT 06104-2999
1-888-563-1124

THE HARTFORD

PART II - Beneficiary's Statement

Federal Law	Federal Law requires us to give you this information. We may have to withhold and send to the IRS 31% of certain reportable payments you may be entitled to. We will not have to withhold this amount if we have your correct Social Security Number, and you state that you have not been notified that you are subject to an IRS back-up withholding order on interest and dividends.

Name of Deceased: Martha A. Starz **Policy #(s):** 442112 **Claim # (if known)** NJ-444451

By signing below:

(1) **I Hereby Certify and Agree** that I have not been notified by the Internal Revenue Services (IRS) that I am subject to a back-up withholding on Interest and Dividends. (If you have been so notified, cross out this statement "(1)." Provide your initials and today's date next to the cross out marks).
(2) **I Hereby Certify and Agree** that I have read and understand the IMPORTANT NOTICE on page 3 of this claim form package.
(3) **I Understand and Agree** that payment of the claim proceeds according to any alternate mode of settlement specified in the policy will only be made if the Company receives a written request for such alternate method of payment from me prior to the payment of the claim proceeds.

MEDICAL RELEASE AUTHORIZATION

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates, or information concerning the deceased or injured's occupation, finances and health including protected health information, individually identifiable health information, summary health information, psychotherapy notes, mental health, HIV, and alcohol/drug records to release all such records in their entirety to Hartford Fire Insurance Company, Hartford Life and Accident Insurance Company, Hartford Life Insurance Company Company, Hartford Life Group Insurance Company and any affiliate of any one or more of these companies (collectively and severally, the "Company"). I understand that I may receive a copy of this authorization, and that this authorization is valid for the entire duration of this claim, and that I may revoke this authorization at any time by sending a request in writing to the Company. I understand that it may be necessary for the Company to provide such information or summaries thereof to the employer, regulatory state agency, or Workers' Compensation carrier.

Beneficiary Name (print): Richard A. Starz
Date of Birth: 5-24-58
X [signature] (Signature): _____ Date: _____
Mailing Address: 4090 Redwood Olive Branch MS. 38654
Social Security [redacted]
Telephone Number: (662) 895-1454

Beneficiary Name (print): _____
Date of Birth: _____
X _____ (Signature): _____ Date: _____
Mailing Address:
Social Security Number: _____
Telephone Number: ( ) _____

Beneficiary Name (print): _____
Date of Birth: _____
X _____ (Signature): _____ Date: _____
Mailing Address:
Social Security Number: _____
Telephone Number: ( ) _____